

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004441	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/19/2012
NAME OF PROVIDER OR SUPPLIER MCKINNEY HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPOUT, IN 46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on March 7, 2012.</p> <p>Survey date: April 19, 2012</p> <p>Facility number: 004441 Provider number: 004441 AIM number: NA</p> <p>Survey team: Tim Long, RN-TC</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census Payor type: Other: 37 Total: 37</p> <p>Sample: 3</p> <p>McKinney House was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure survey.</p> <p>Quality review completed on April 26, 2012 by Bev Faulkner, RN</p>	{R 000}			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1